IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
MARSHALL DIVISION

RANDALL GOODWIN,	§	
	§	
Plaintiff,	§	
	§	
V.	§	Civil Action No.
	§	
LIFE INSURANCE COMPANY OF NORTH AMERICA	§ §	
	§	
Defendant.	§	

COMPLAINT

Plaintiff Randall Goodwin, for his Complaint against Defendant Life Insurance Company of North America, would show as follows:

Parties, Jurisdiction and Venue

1. Plaintiff is an individual citizen of Texas.

2. Defendant is a corporation and, on information and belief, may be served through its registered agent for service of process in Texas, CT Corporation System, 1999 Bryan Street, Suite 900, Dallas, Texas 75201.

3. Jurisdiction is proper on the ground of the existence of a federal question under 28 U.S.C. § 1331 based on Plaintiff's claim under the Employee Retirement Income Security Act, 29 U.S. C. §1001 et seq. ("ERISA").

4. Venue is proper.

Facts

5. Prior to February 2012, Plaintiff was employed with Lockheed Martin Corporation for nine years in various management positions, and through such employer, covered by a short-term disability benefits policy administered by Defendant and a long-term

disability benefits policy administered and issued by Defendant. As of January 31, 2012, Plaintiff could no longer continue work as a result of impairments associated with memory issues and vascular dementia, and made a claim to benefits under the short-term disability benefits policy and received such benefits. Upon exhaustion of short-term disability benefits, he then further made a claim to benefits under the long-term benefits policy and received such benefits for 24 months, beginning June 29, 2012, through June 29, 2014.

6. By letter dated June 26, 2014, Defendant denied long-term disability benefits to Plaintiff as of June 30, 2014.

7. By letter dated July 31, 2014, Plaintiff appealed Defendant's June 26, 2014 denial of long-term disability benefits.

8. By letter dated November 7, 2014, Defendant reiterated its denial of long-term disability benefits to Plaintiff.

9. By letter dated August 18, 2015, Plaintiff appealed Defendant's November 7, 2014 denial of long-term disability benefits.

10. After Plaintiff's August 8, 2015 appeal, Defendant failed, within 45 days, to make a determination of Plaintiff's appeal, or request an extension to do so based on special circumstances, as required by 29 CFR 2560.503-1(i)(3), or make a determination within the period permitted by any such extension.

11. By letter dated March 17, 2016, Defendant reiterated its prior June 26, 2014 and November 7, 2014 denials of long-term disability benefits to Plaintiff.

12. By its June 26, 2014, November 7, 2014 and March 17, 2016 denials, Defendant improperly relied upon a standard of disability distinct from that provided for in the governing policy, improperly ignored Plaintiff's medical condition and testing of such condition and

specific determinations of Plaintiff's disability based on such condition, improperly ignored certain medical records of Plaintiff, improperly misrepresented certain medical records of Plaintiff, improperly dismissed the significance of other medical records of Plaintiff and improperly ignored other statements of Plaintiff's impairments. Among other things, in the November 7, 2014 denial, Defendant relied upon an evaluation of a physician which characterized Plaintiff in a misleading fashion and contained numerous false observations. Defendant, in the November 7, 2014 denial, also ignored a Disability Questionnaire and Activities of Daily Living forms completed by Plaintiff which it had solicited.

13. In connection with its disposition of the claim of Plaintiff under the long-term disability benefits plan, including its denial of benefits to Plaintiff by its June 26, 2014, November 7, 2014 and March 17, 2016 denials, CIGNA engaged in conduct not consistent with its fiduciary duty to Plaintiff under ERISA and in violation of provisions of ERISA and regulations promulgated pursuant to ERISA, including Section 1133(2) of ERISA, requiring that a participant whose claim for benefits has been denied be afforded a reasonable opportunity for a full and fair review by the appropriate named fiduciary of the decision denying his claim, one or more of the requirements of 29 CFR 2560.503-1(b)(5) that benefit claim determinations be made in accordance with governing plan documents and that plan provisions be applied consistently with respect to similarly situated claimants, the requirements of 29 CFR 2560.503-1(g) as to the content of any adverse benefit determination, the requirement of 29 CFR 2560.503-1(h)(2)(iv) that a fiduciary take "into account all comments, documents, records and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination," the requirement of 29 CFR 2560.503-1(h)(3)(iii) that any medical judgment must be the result of consultation with a health

care professional with appropriate training and experience in the field of medicine involved in the medical judgment, the requirement of 29 CFR 2560.503-1(h)(3)(iv) that any medical or vocational experts whose advice was obtained in connection with an adverse benefit determination by identified without regard to whether the advice was relied upon in making the benefit determination, the requirement of 29 CFR 2560.503-1(h)(3)(v) that any health care professional consulted in connection with any adverse benefit determination be an individual who was not consulted with the adverse benefit determination that was the subject of the appeal, nor a subordinate of such individual, and the requirements of 29 CFR 2560.503-1(j) as to the manner and content of a benefit determination on review.

14. Based on the terms of the governing long-term disability benefits policy, Defendant's denial of benefits is subject to de novo review and, so reviewed, must be determined to have been wrong, Alternatively, based on Defendant's violation of one or more requirements of 29 CFR 2560.503-1, Defendant's denial of benefits is subject to de novo review and, so reviewed, must be determined to have been wrong. Alternatively, based on the application, pursuant to 29 U.S.C. § 1144(b)(2)(A), of Section 1701.062 of the Texas Insurance Codes and Title 28, Part 1, Chapter 3, Subchapter M, Rules 3.201(c), 3.1202 and 3.1203 of the Texas Administrative Code, 28 Texas Administrative Code 3.201 et seq. Defendant's denial of benefits is subject to de novo review and, so reviewed, must be determined to have been wrong. Again in the alternative, in the event Defendant's denial of benefits is subject to review only for abuse of discretion, Defendant, to the extent of any discretion, abused such discretion.

15. Notwithstanding its improper denials of long-term disability benefits by Defendant, Defendant claims that it overpaid Plaintiff long-term disability benefits in the amount of $41,920.67. In light of the fact that its June 26, 2014, November 7, 2014 and March 17, 2016

denials were unlawful, and under other applicable law, such a claim of overpayment is also unlawful and should be denied.

Claim

16. For his first cause of action, Plaintiff would show that Defendant wrongfully denied benefits due to his under the long-term disability benefits policy as of, and after, June 30, 2014. Defendant is accordingly liable under Section 1132(a)(l)(B) of ERISA for all benefits due but not paid to Plaintiff under the long-term disability benefits policy, prejudgment interest and his attorney's fees and expenses and costs of court.

17. For his second cause of action, Plaintiff would show that he is entitled to a declaratory judgment that Defendant is not entitled to the alleged overpayment of benefits from him.

WHEREFORE, Plaintiff prays this Court grant his judgment against Defendant for all appropriate relief.

Respectfully submitted,

/s/ Robert E. Goodman, Jr.
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